APPLICATION FOR NEVADA DENTAL HYGIENE EXAMINATION

I hereby make application for ADEX Dental Hygiene Clinical Examination administered by NSBDE:

2" x 2" color photo of applicant taken within the last 6 months must be uploaded to profile on NERB website.

ADEX Approved Dental Hygiene Clinical Exam Administered by: (NRS 631.300)

NSBDE $750 _____ (NERB---$225) ($975--Total fee is collected by NERB via online registration only)

NOTE: ***An application is considered complete when the application, all required documents and fees are on file with the Board office. APPLICATION FEES MUST BE PAID IN ADVANCE BY CREDIT CARD ONLINE WITH NERB AND MAY NOT BE REFUNDED PURSUANT TO NEVADA REVISED STATUTE (NRS) 631.345. YOU WILL BE NOTIFIED WITHIN 15 BUSINESS DAYS UPON APPROVAL OF YOUR APPLICATION BY THE BOARD. ONLY COMPLETED APPLICATIONS WILL BE REVIEWED.***

Please type or print legibly. All questions must be answered. If additional space is needed, attach a separate sheet identifying additional information by Section number. OMISSIONS, INACCURACIES, AND/OR MISREPRESENTATIONS OF INFORMATION ARE GROUNDS FOR REJECTION OF APPLICATION. Applicants acknowledge they have a continuing responsibility to update all information contained in this application. Failure of an applicant to update the information prior to final action of the Board is grounds for rejection of the application and restriction from examination. Updates must be made online at NERB website AND with NSBDE.

1. FULL NAME _____ SOCIAL SECURITY #_____

Have you ever been known by any other name? Yes _____ No _____

If yes, state in full every other name by which you have been known, the reason therefore, and the inclusive dates so known: _____

_____

_____

If a name change was made by court order, attach a CERTIFIED COPY of the court order.

If a married woman, state maiden name: _____

2. ADDRESS

Mailing Address _____

_____

Permanent Address _____

(If different) _____

Practice Address _____

(If any) _____

Telephone Residence ( )_____

Telephone Cell ( ) _____

Telephone Business ( )_____ FAX ( )_____

e-mail address _____@_____

3. AGE _____ Birthdate _____ Birthplace _____
(City, County, State, & Country)

4. DENTAL HYGIENE SCHOOL EDUCATION

Dental Hygiene School _____

City & State _____

Years attended From _____ (Month & Year) To _____ (Month & Year)
(If graduated, final transcript must be submitted to the NSBDE)

Section#5 should only be completed by those not yet graduated from a dental hygiene program.

5. CERTIFICATION FROM DEAN/ PROGRAM DIRECTOR OF APPLICANT'S DENTAL HYGIENE SCHOOL

I HEREBY CERTIFY that _____ attended
(Name of Applicant)
_____ from _____ to _____
(Name of School) (Date) (Date)

AND *(please check and complete appropriate line)*

is expected to graduate on the _____ day of _____, 20_____, with a degree of _____ and is sufficiently prepared to participate in the ADHLEX examination given by NSBDE.

BY _____
OFFICIAL SEAL
OF ACCREDITED DENTAL HYGIENE
COLLEGE OR UNIVERSITY
(Original Signature of Dean/Program Director) ***no stamped signatures***

_____
(Printed Name of Dean/Program Director)

6. AUTHORIZATION OF RELEASE OF SCORES

I, _____ hereby authorize the NSBDE to release my individual examination scores
(Name of Applicant)
to my dental hygiene school of record to facilitate any remediation that may be needed.

Yes_____ No_____

7. AFFIDAVIT AND PLEDGE

I further authorize and empower the Nevada State Board of Dental Examiners to release my individual examination scores to any testing agency or licensing agency.

I hereby authorize educational and other institutions, insurance carriers, professional societies, governmental agencies and instrumentalities (local, state, federal or foreign), and independent information gathering services to release to the Nevada State Board of Dental Examiners any information, files or records requested by the Board in connection with the processing of this application.

I hereby pledge myself to the highest standards and ethics in the Examination for Dentistry and further pledge to abide by the laws and regulations pertaining to the examination in dentistry. I understand that a violation of this pledge may be deemed sufficient cause for the rejection of my application.

I UNDERSTAND THAT ANY OMISSIONS, INACCURACIES, OR MISREPRESENTATIONS OF INFORMATION ON THIS APPLICATION ARE GROUNDS FOR REJECTION OF THIS APPLICATION.

STATE OF _____

COUNTY OF _____

Signature of Applicant _____

(Notary Seal) **Date** _____

Signature of Notary _____